

Application for License to  
Operate a Long-term Care Facility

For Office Use Only  
Received 9/14/09  
Amount \$ 510.

Ch#  
028675

emailed validation letter  
9/23/09

I. IDENTIFICATION

Name Telford Terrace  
Address 1025 Robert L Telford Dr  
City/County/Zip Richmond, Madison, 40475  
Telephone number (859) 626-5200 telford.terrace@dsl.chpl.net  
Administrator Gilbert S Shew  
Date facility operation began at current address September 2000  
Date facility began operation under current owner September 2000



II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	<u>                    </u>	<u>                    </u>
Nursing Home	<u>34</u>	<u>34</u>
Nursing Facility	<u>                    </u>	<u>                    </u>
Intermediate Care	<u>                    </u>	<u>                    </u>
ICF/MR	<u>                    </u>	<u>                    </u>
Personal Care	<u>                    </u>	<u>                    </u>

II. CONTROL (check one in each column)

State	Profit	Individual
County	<u>Nonprofit X</u>	Partnership
City		<u>Corporation X</u>
<u>Private</u>	X	

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

McCreedy Manor, Inc  
300 Stocker Dr  
Richmond, KY 40475

(OVER)

9/30

If facility owned or leased by a corporation, complete the following:

Name of corporation	McCready Manor, Inc
Address of corporation	300 Stocker Dr
President or Chairman	Ron Coffman
Vice President	Jim Ney
Secretary	Ginger Wallace
Treasurer	Bob Lilly

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
_____	_____
_____	_____
_____	_____

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

_____ Signature of authorized representative	_____ Title	_____ Date
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Return Application and fee to:

Office of Inspector General  
275 East Main Street, 5E-A  
Frankfort, Kentucky 40621

OIG 5  
(10/2002)